ANOKA COUNTY
Sexual Assault Victim Fund

Dear Applicant,

Please complete the attached application for funds to the best of your ability. Incomplete applications may cause a delay in processing. All applications for financial assistance from the Sexual Assault Victim Fund are reviewed by the Anoka County Sexual Violence Services Professionals Committee. The review committee may confirm that you have reported your incident to a mandated reporter and may also verify the existence and/or credentials of the person and/or program to which you are requesting payment.

The amount of money and the person or agency to which the cost should be remitted must be clearly identified. A maximum of $1,000 can be paid out per incident per applicant. When the application and any supplemental documents have been received by the Anoka County Sexual Violence Services Professionals Committee, you will be contacted by email or telephone regarding notification of the receipt of the application. Any additional materials or documentation will be requested at that time if the application is incomplete. A formal letter stating approval and the amount granted or disapproval will be mailed to you within seven (7) business days of receipt of the application submission. The Sexual Assault Victim Fund treasurer will mail payment to the designated payee within 30 days in the case of approval.

Before submitting your application, please verify that you meet all of the following **eligibility requirements**:

1. Applicant must be a current resident of Anoka County, OR the sexual assault must have occurred within Anoka County.
2. Requests for financial assistance must pertain to expenses incurred because of the sexual assault.
3. The applicant needs to demonstrate that all other means of reimbursement have been exhausted.
4. Applicant must have disclosed the sexual assault to a mandated reporter (law enforcement, social services, school personnel, victim services program staff, counselor or therapist, etc.).
5. The applicant must sign a release of information to any entities to which payment has been requested.

Completed application and applicable documentation should be submitted to:

Alexandra House, Inc.
Healthcare Coordinator
10065 – 3rd Street NE
Blaine, MN 55434
Fax: 763-780-9696
Phone: 612-479-5953
Email: HCAdvocate@alexandrahouse.org

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APPLICATION FOR FINANCIAL ASSISTANCE

Please remit questions to the Alexandra House, Inc. Healthcare Coordinator at ***612-479-5953.***

1. Victim Information

Name of Victim: _____
(Last) (First) (MI)

Date of Birth:_____

Street Address: _____

City:_____Zip Code:_____ County: _____

Home Phone #:_____Cell/Work Phone #:_____

Email Address: _____

How did you hear about this fund?_____

2. Incident Information: Date of assault:_____County in which assault occurred: _____

Please check the agencies/persons to which the sexual assault was disclosed:

	Approximate date of disclosure	**Phone Number**
❍ Law Enforcement	____/____/____	#_____
❍ Social Services	____/____/____	#_____
❍ Child Protection Services	____/____/____	#_____
❍ School Personnel	____/____/____	#_____
❍ Victim Services Program	____/____/____	#_____
❍ Counselor/Therapist	____/____/____	#_____
❍ Other _____	____/____/____	#_____

RELEASE OF INFORMATION

I,_____*(applicant name)* authorize the Sexual Violence Services Professionals Committee and any of its members to obtain information from and disclose information to *the above checked mandated reporters* regarding my disclosure of a recent incidence of sexual assault.

Signature:_____ Date: _____

3. Request for Funds Amount requested: $_____(maximum $1,000)

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Applicant must demonstrate that all other means of reimbursement have been exhausted prior to this application.

Please list all other financial sources accessed for assistance/repayment:	Was your request for assistance approved?	How much were you awarded?	What costs did the monetary award cover?
	❒ Yes ❒ No	**$**	
	❒ Yes ❒ No	**$**	
	❒ Yes ❒ No	**$**	
	❒ Yes ❒ No	**$**	

Please provide an itemized list of all requests for financial assistance/reimbursement for costs not covered by other sources. *(Items must pertain to expenses incurred as a result of the sexual assault*):

_____

_____

_____

_____

Please provide contact information for all parties to which payment is requested (healthcare facility, daycare, therapists, self, etc.)
**** Attach additional payee contact information if needed.***

Name:_____ Name:_____

_____ _____

Address:_____ Address: _____

Phone #:_____ Phone #: _____

Please complete ONLY if you are requesting financial assistance for medical bills related to the incident.

Do you have health insurance coverage? ❒ Yes ❒ No
If yes, have you submitted these costs to the insurance company? ❒ Yes ❒ No
If you answered "NO" to any of the above questions, please explain:

PLEASE INCLUDE A COPY OF THE PATIENT RESPONSIBILITY STATEMENT WITH THE VICTIM'S NAME AND SERVICES RENDERED.

NOTE: *If you are requesting payment of outstanding bills, attach a copy of the bill with the account number. If you are requesting reimbursement of transportation costs, include the number of miles and verification of visits to therapists, court, etc. If you are requesting reimbursement for lost wages, we cannot consider this expense if sick/vacation time was available. If not, include the amount of wage and the number of hours.*

4. Please describe in detail how your request for funds directly relates to the incident of sexual assault:

Attach additional pages if necessary.

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I acknowledge and agree that all or any part of the payment awarded may be paid directly to the supplier of services/aforementioned parties to which payment is requested on my behalf, and authorize them to release any information that will verify the amount of services rendered and the cost of those services to the Anoka County Sexual Violence Services Professionals Committee.

Applicant Signature: _____ Date: _____

Please submit your application by mail to:

Alexandra House, Inc.
Healthcare Coordinator
10065 – 3rd Street NE
Blaine, MN 55434

Email: HCAdvocate@alexandrahouse.org